

ATTACHMENT 2b

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE

129

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Patient, Is A.			
5 DATE OF BIRTH 07/15/75	6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: Day Treatment Provider 1 W. Williams Anytown, WI 55555		9 BILLING PROVIDER NO. 87654321	
		10 DX: PRIMARY 296.33 Major depression	
		11 DX: SECONDARY 305.00 Alcohol abuse	
		12 START DATE OF SOL	13 FIRST DATE RX

14	PROCEDURE CODE	15	MOD	16	POS	17	TOS	18	DESCRIPTION OF SERVICE	19	QR	20	CHARGES
	W7081				2		9		Adolescent Day Treatment		150		

22 An approved authorization does not guarantee payment.

Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL
CHARGE

21

23 MMDDYY

DATE

24

REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION

☐
APPROVED

☐
MODIFIED

☐
DENIED

☐
RETURN

REASON

REASON

REASON

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

DATE

CONSULTANT ANALYST SIGNATURE